EXHIBIT A

MultiPlan

2018 Client Advisory Board Meeting

Payment Integrity Focus

Christopher Dorn
Senior Vice President

Fighting Medical Waste & Abuse

Driven by size and complexity, an estimated 3-10 percent of annual U.S. healthcare spending is wasteful, abusive or outright fraudulent

Sources: CMS, CAHQ, Rand Corporation, US Census Bureau, NHCAA

The Payment Integrity Solution Set

Targets clinical waste and abuse for medical claims/bills

Clinical Negotiation

- Pre-payment
- Expert reviews and provider outreach to address coding and clinical issues and egregious charges
- Results in agreement for a reduction in charges

Claim/Bill Correction

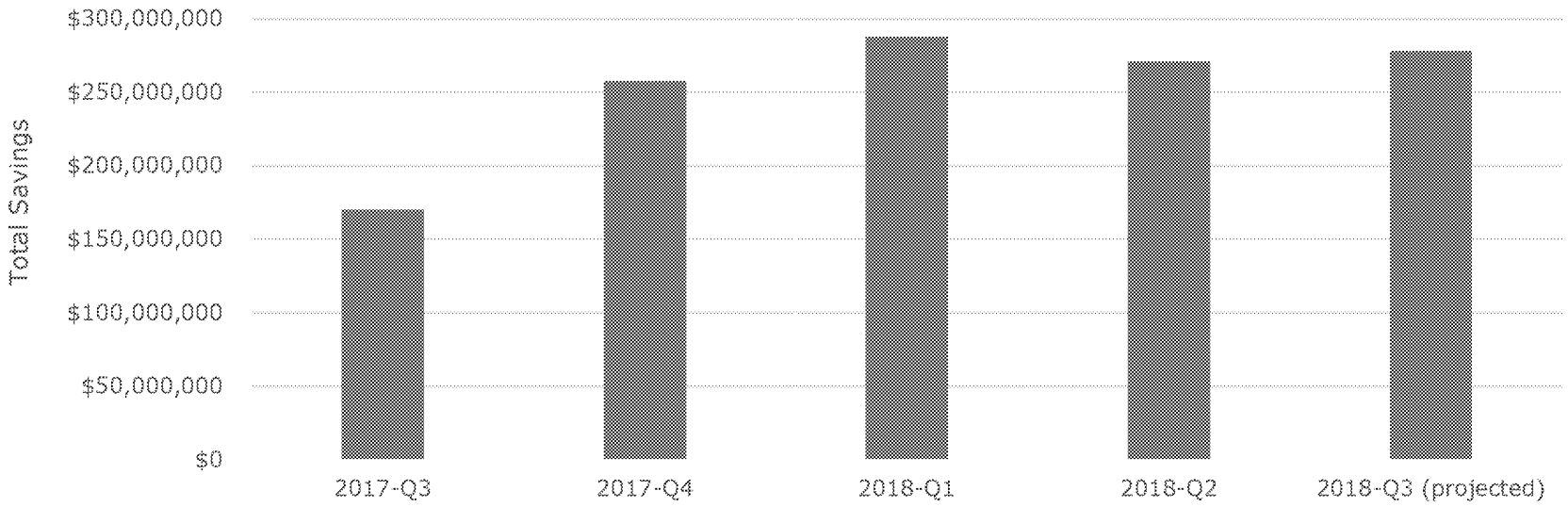
- Pre-payment
- Expert reviews that enforce national procedure and diagnosis billing standards
- Results in defensible elimination of inappropriate charges

High Dollar Audit

- Pre- or post-payment
- Broader set of factors/ triggers
- Charge, coding and clinical review of itemized facility bills and medical records
- Identifies and mitigates material overpayments

Results to Date

$1 billion payment integrity savings in the last 12 months



Note that Q1 is historically the largest quarter due to year-end closing activity.

Example: Over-Coding

Ambulatory surgery center

- Spinal pain injection with standard imaging guidance
- Provider reported a more complex diagnostic test (epidurography) incorrectly as imaging guidance to get around guidance edits
- In addition, provider charges are in top 10% for the spinal injection
- Charges on this claim/bill: $25,000
- Clinical Negotiation savings: 99%

Charges	$25,400
Savings	$25,072
Price	$328

Example: Play It Again

Up-coding of intraoperative neuro monitoring

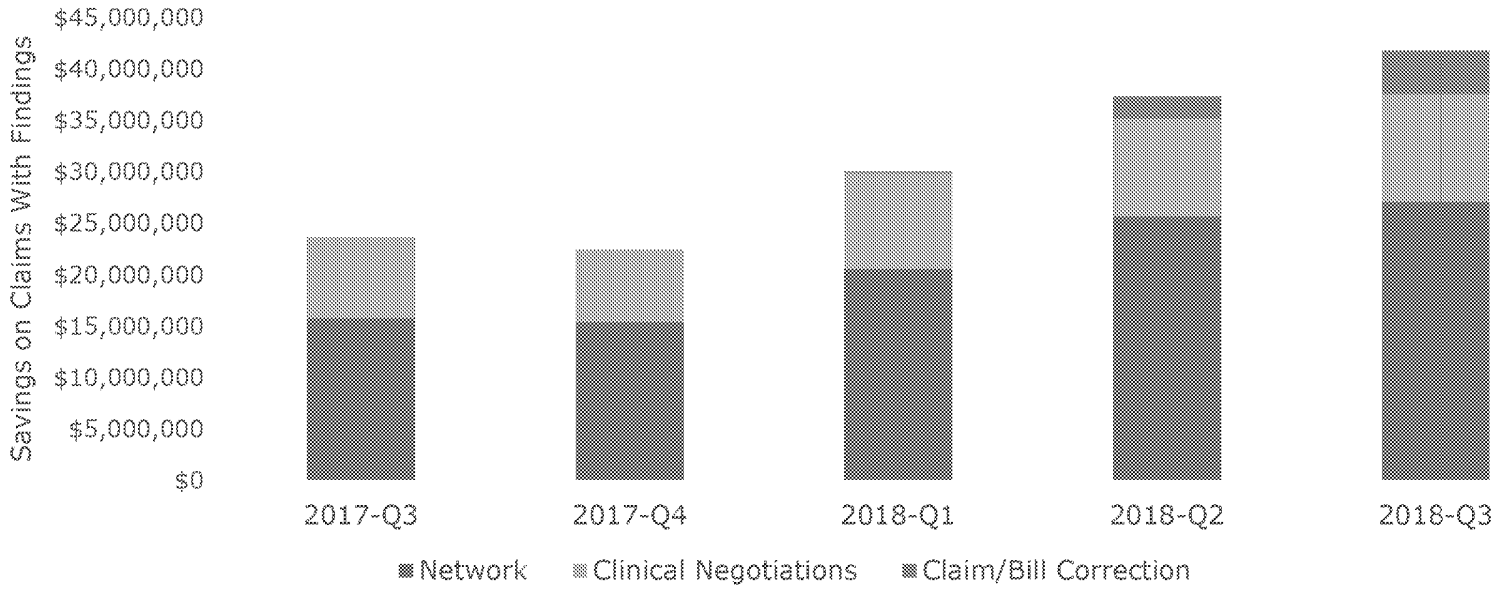
- IONM with four baseline tests
- One baseline test was up-coded
- Selecting a code based on a piece of equipment being used rather than the service being performed
- The provider up-codes this way on a high percentage of claims/bills
- Clinical Negotiation savings: 88%

Charges	$29,607
Savings	$26,007
Price	$3,600

MultiPlan Network Pricing Integrity

Improved accuracy and savings by removing waste/abuse

380 clients live as of July with payment integrity services embedded



Example: Full of 88 Holes

Same patient, same provider, same service date

First Claim/Bill

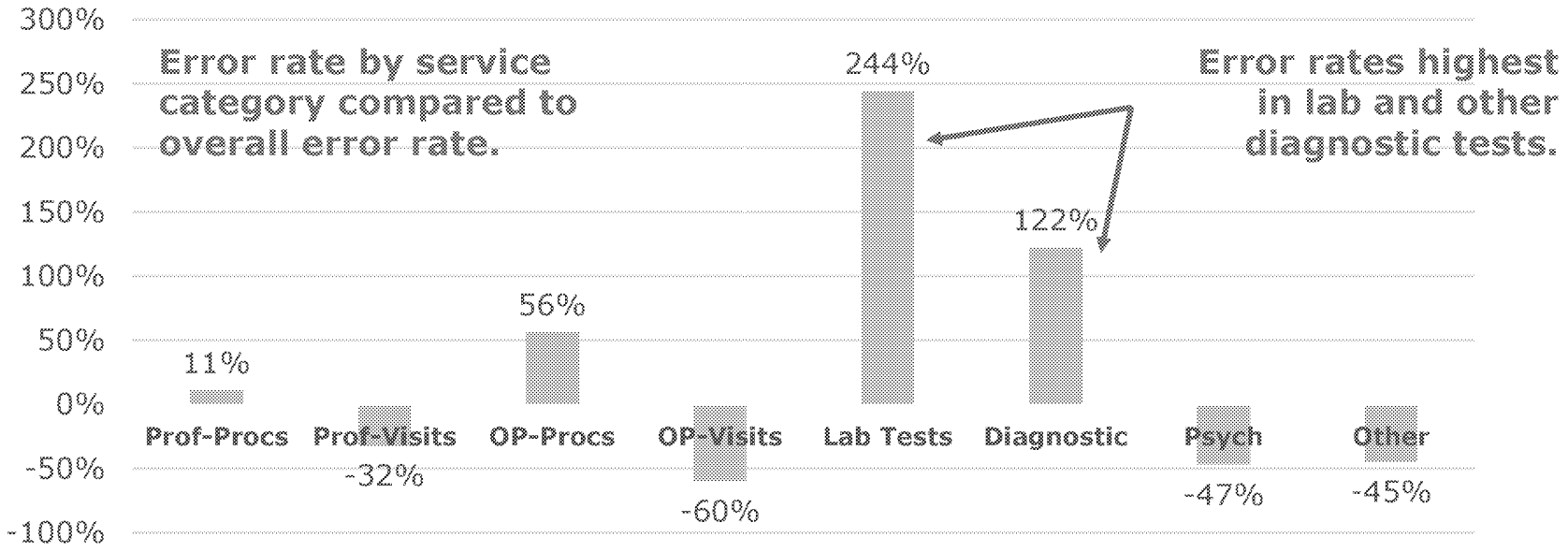
- Provider submitted 34 tendon injections
- All diagnoses were unspecified sites
- Network allowed of $1,801 (48.2% discount)
- Correction findings of $1,427
- Total cost reduction: $3,366 (90%)

Second Claim/Bill

- Submitted office visit
- 29 different tendon injections and 25 joint injections
- All diagnoses were unspecified sites
- Network allowed of $2,709 (48.5% savings)
- Correction findings of $2,161
- Total cost reduction: $4,870 (90%)

Client Network Pricing Integrity

Claim/bill correction rates range from 0.5% to 1.5%



Example: Gender Bender

Laboratory testing – low dollar but high volume

- Lab claim/bill with blood collection and two tests
  - Patient was male with renal artery atherosclerosis
  - OB panel (10 common tests for pregnant women)
  - Hepatic function panel (7 tests to measure liver function)
- Claim/Bill Correction savings: 46%

Allowed	$156
Savings	$72
Price	$84

Example: High Dollar Bill Review

- Review of itemized bill:
  - 36-day inpatient stay; $3.8M billed charges
  - $2.8M charged for operating room time with 12-20 hours of time reported on the majority of days during the stay
  - No significant surgical procedures reported
- Review of medical record:
  - No surgery was performed after the first day of the hospital stays
  - Identified extra ventilator charges on days when ventilator was not used

Charges	$3.8M
Savings	$2.0M
Price	$1.8M

Example: Workers' Compensation

Savings is identified even after client bill review

- Knee surgery for workers' compensation injury
- Provider reported six different procedures on one knee
- Client's bill review process found edits on two procedures
- We recommended payment on only one procedure

Allowed	$5,865
Savings	$4,753
Price	$1,112

Maintaining Focus

Continuous investment in payment integrity

- Currently analyzing about 125,000 claims/bills a day
- Staff dedicated to payment integrity has grown significantly
  - 40 nurses/coders
  - 14 physicians
  - 20 researchers
  - 12 analysts/developers
- Continue to add rules to the system on a monthly basis
  - Code combinations exceed 300 million

Maintaining Focus

Continuous innovation in resolution services

Service	Value
Pre-pay medical record review	◦ Uses more factors ◦ Resolves more complex issues
Immediate audit	◦ Uses all factors ◦ Bridges pre- and post-payment
Provider centric review	◦ Uses all factors ◦ Specific service types and providers ◦ Bridges financial and clinical abuse

Inspiring Vision
Our investment in DentaLens

- Follows on our success in bringing a young MARS technology to market
- Serves a large and growing market:
  - 2016 total spend over $124 billion
  - 3.3% growth over 2015
- Addresses a significant and difficult-to-address need for improved payment accuracy
- Spans commercial and government markets

Source: Health Policy Institute, American Dental Association

Inspiring Vision

MultiPlan now does for dental what we do for medical

	MultiPlan (Medical)	DentaLens (Dental)
Pre-payment focused	✓	✓
Clinically driven	✓	✓
Targeting waste, abuse and fraud	✓	✓
Complements existing programs	✓	✓
Supports client internal payment integrity teams	✓	✓
Service delivery model	✓	✓
High automation – low dollar capable	✓	✓

Inspiring Vision

MultiPlan and DentaLens

Source: National Health Care Antifraud Association

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Next Speaker:

Richard Klich, DMD

DentaLens

About DentaLens

The only fully-automated pre-payment solution for dental waste, abuse and fraud

- Architected by dental experts, guided by a board of experts and advisors with ***over 120*** years of dental experience
- Focused on detecting the low dollar, high volume, repetitive issues that are ROI intensive and account for ***80-90%*** of dental waste, abuse and fraud
- Detects issues ***early, with precision***, and while they're still small
- Applies clinically-driven, intelligent algorithms in a ***pre-payment*** process to identify and correct issues that editing can't

How Our Service Performs

Delivers five times more savings within weeks, not years

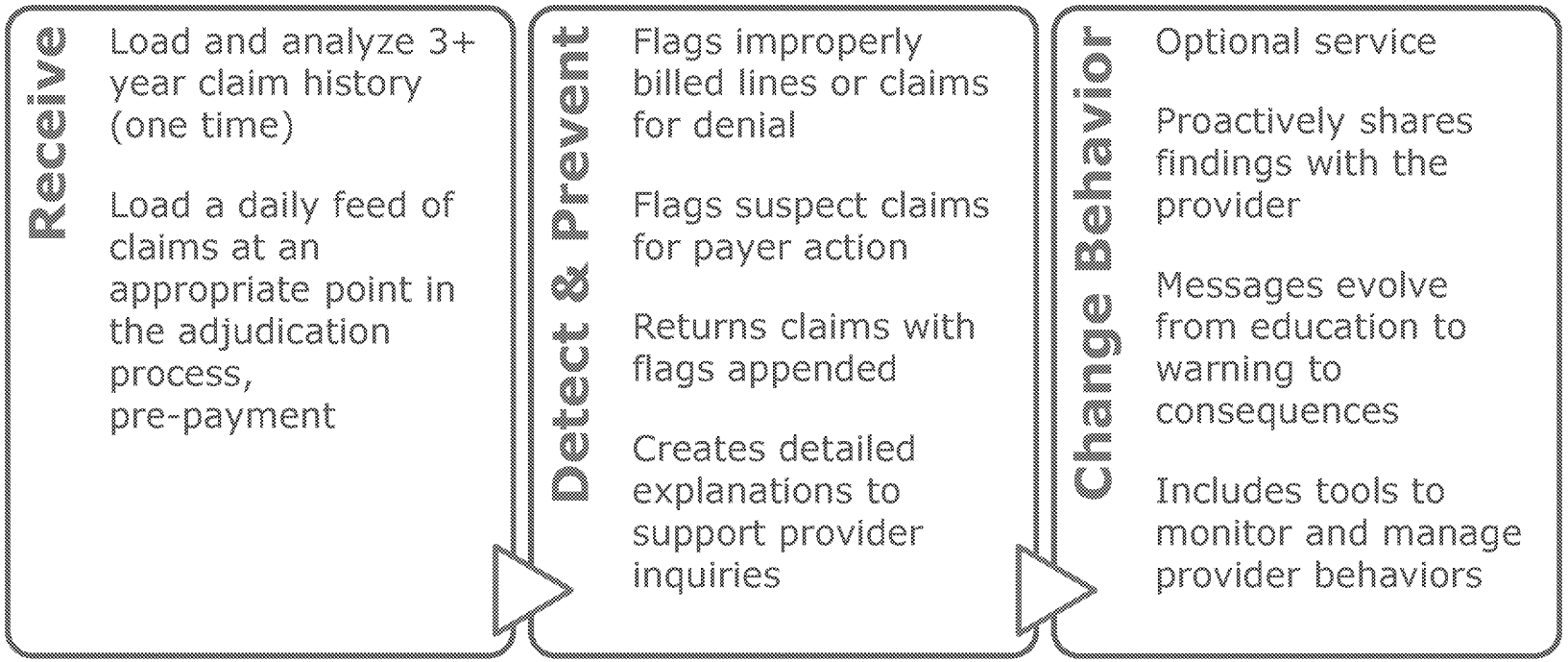
We detect improper billing leading to cost reduction of 5-7%, or $12-21 PMPY*

Example: Medicaid Plan	
Members:	223,022
Claims Analyzed:	447,050
Paid $ Analyzed:	$69,932,339
Savings Per Year:	$4,198,961
% Saved:	6%
PMPY Savings:	$18.83

Example: Commercial Plan	
Members:	10,000,000
Claims Analyzed:	62,055,231
Paid $ Analyzed:	$12,956,026,503
Savings Per Year:	$213,239,002
% Saved:	5%
PMPY Savings:	$21.32

* Based on analysis of over half a billion paid claims from 80 million private and public sector dental plan members

Process Overview

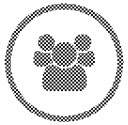


What We Find

Algorithms capture dental knowledge, informatics and forensics, best practices and guidelines

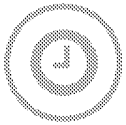
Recommend denial with line-level precision

Specific Procedures
Crown buildup, unnecessary x-rays, etc.

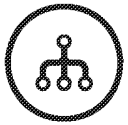


Impossible Procedures
Age bound e.g., crown performed on a toddler

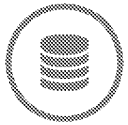
Flagged for payer action, as appropriate



Time Bound
Doctor with patient, patient in chair



Physical Connections
Between dentists and patients, referrals, distance, etc.



Statistical Detection
Overutilization of procedures, codes, etc.

Example: Specific Procedures

Line-level findings with precision

- Dentists may charge for a regular extraction when a baby tooth is about to fall out on its own.
- In some cases, the baby tooth does not fall out on its own and the dentist extracts the baby tooth.
- The dentist charges for the regular extraction rather than a baby tooth extraction and essentially doubles the reimbursement.

Specific Client Experience

Times Occurred	799
Total Savings	$29,000

Example: Impossible Procedures

Line-level findings with precision

- A dentist will sometimes submit a claim for a treatment that is impossible to do.
- One example is a filling on a five-year old, on an adult molar tooth.
- At age five, the adult molar has not yet appeared in the child's mouth.
- When we combine the biologically impossible with policy age limitations, we find a significant occurrence of procedures that could or should not be done.

Specific Client Experience

Times Occurred	3,677
Total Savings	$379,000

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Example: Time Bound

Findings flagged for payer action

- Most dental procedures must be done by the dentist.
- There is a limited number of procedures that the dentist can do in a given day.
- We calculate the time it takes to do all the procedures in all the claims in a day and compare this to the amount of time available to do the procedures.
- In a recent analysis of a Medicaid insurer, this scheme amounted to $1.3 million loss in 2016.

Max Time	576
Billed Time	1,038
Savings	44.5%

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Example: Physical Connections

Findings flagged for payer action

- A dentist may collude with another dentist to increase payments to both.
- We look at the pattern of shared patients to see if there is a suspicious pattern.
- Once detected, a detailed analysis reveals the details of the cooperation.
- In one case, we discovered a corporate practice in which different providers within the same office conducted duplicate procedures -- in other words, the office got paid twice.

Shared Patients	25
Duplicate Code	23 (D9450)
Duplicate Fee	$84

Example: Statistical Detection

Findings flagged for payer action

- Because we analyze claims every day, we update the statistical analysis every day.
- Thus we can detect the providers who cross the statistical threshold very early.
- In one case, we found a general dentist who did 40 extractions in a month and 39 of the 40 were complicated surgical extractions.
- The average for the entire General Dentist population was about 1 to 1. So clearly 39:1 is well outside of the norm.

Specific Client Experience

Bad Billers	2,780
Total Savings	$3.9M

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Comprehensive Evidence

Delivered to a provider portal, or by you directly

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Claim ID – 123abc456

3rd Molar extraction code used for non-3rd molars

The details below provide **SUFFICIENT EVIDENCE** to assert inappropriate dental claims on the provider under review.

Detailed Analysis of Third molar extraction codes used fo

Line Item	Tx Code	Description	Tooth #	Fee
1.	D0210	Intraoral – complete series of radiographic images		12
2	D0120	Periodic oral evaluation – established patient		10
3	D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	14	31
4	D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	16	31
5	D1110	Prophylaxis - Adult		

Discussion

This algorithm looks at the use of impaction extraction codes inappropriately. The following are the reasons for denial or allowance:

1. The treated tooth is a 3rd molar which is generally the tooth that suffer from impactions. This is flagged green.
2. The treated tooth is NOT a 3rd molar and treatments codes for the extraction of impactions are generally applicable only to 3rd molars. There is no evidence that this tooth in impacted. This is flagged red.
3. There is no tooth number associated with this procedure. This is flagged red.

If there is any Third molar extraction code violation, then the provider is flagged red. If there is no tooth number associated with the treatment code, the treatment is disallowed. Otherwise, the treatment code is downcoded to D7140.

If there is no Third molar extraction code violation, then the provider is flagged green.

In this case, the provider is flagged red in line item 3.

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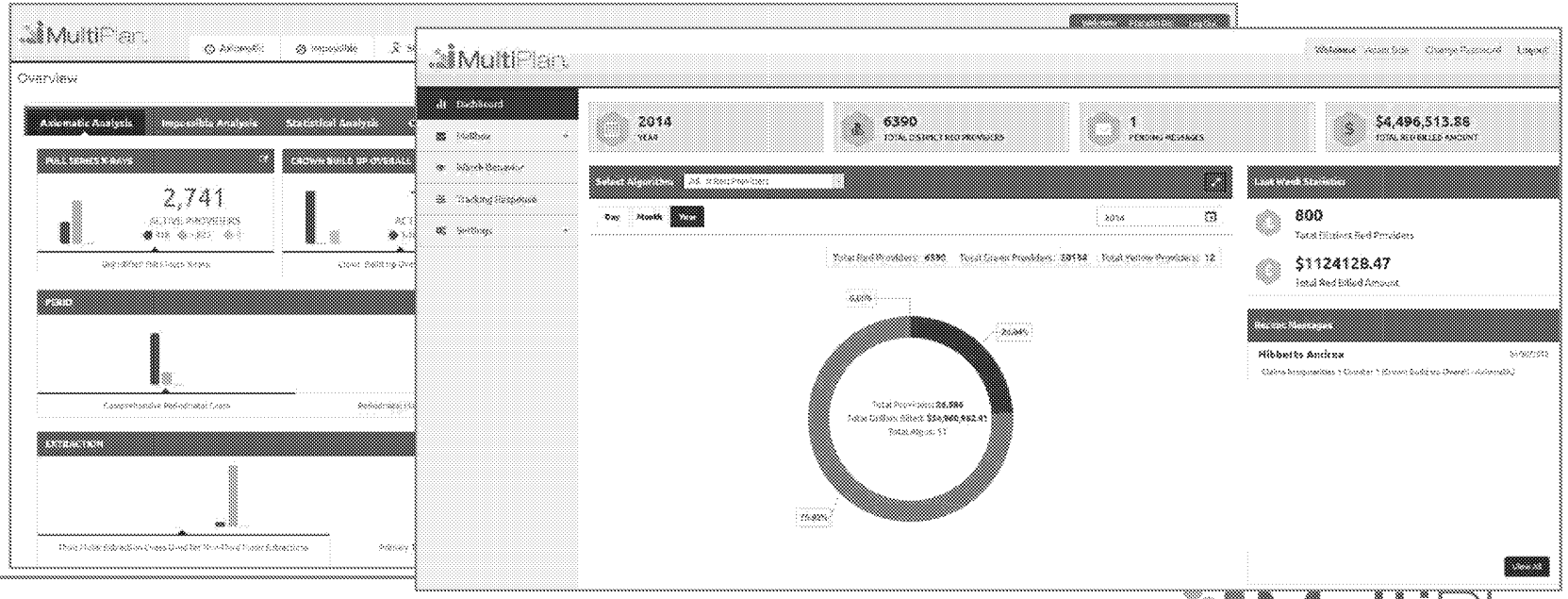
Deep Knowledge at Your Fingertips

Actionable claim findings and valuable insights into your provider network



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Changing Behavior

Proactive, increasingly pointed communications

Dear Franklin Din,

During a recent claim monitoring process, we have discovered discrepancies with your claim(s) that must be addressed

Dear Franklin Din,

) alert

We have continued to notice the same claim(s) discrepancies that we first detected on 2015-08-15. **Perhaps you have not had the time to investigate and correct the clerical process that led to the discrepancies.** We urge
quickly as possible. You can
messaging URL>>.

Please recheck your claim ar
<<the messaging URL>>.

Thank you,
<<the messaging URL>

Dear Franklin Din,

Despite our continuing efforts over the last several weeks to correct a persistent problem with your claims, we continue to see the same problem. There is no evidence that you have made any effort to rectify the problem. We have exhausted all attempts **to remedy the coding irregularities. Therefore, please consider this as your final warning and address the issue within the next 10 days.** After that date, all the evidence of claims irregularities will be submitted to enforcement authorities, including but not limited to, the State Professional board, OIG, and AG for any disciplinary actions.

You can access the claim(s) in question plus the supporting explanatory
messaging URL>>. You may also contact us at the